STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175554	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Medical Center Ltcu	1625 S Franklin Avenue Colby, KS 67701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 44 residents with three residents reviewed for neglect. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1 who had a history of respiratory failure and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) received the required respiratory services. On 05/21/24 at 09:58 AM Certified Nurse Aide (CNA) M failed to provide R1's continuous oxygen at 4 Liters (L) per minute for forty-five minutes, while staff provided R1 a bath. At 10:45 AM CNA M assisted R1 back to his wheelchair after bathing and dressing him; when R1 sat down he became unresponsive. Certified Medication Aide (CMA) R entered the bathhouse and noted R1 had no color and was struggling to breathe. Licensed Nurse (LN) G then entered the bathhouse and noted R1 with his head back and was extremely pale. LN H entered the bathhouse and saw R1's eyes rolled into the back of his head, greyish skin color, and no respirations. The staff obtained R1's vital signs and noted zero respirations and an oxygen saturation of 76 percent (%). LN H noticed R1 did not have his oxygen on and requested an oxygen cylinder be brought to the room. Staff administered R1 oxygen at 4L per minute by nasal cannula per R1's orders. R1 became responsive for a moment and verbalized he could hear staff and then lost consciousness again. R1's breathing was irregular and labored and R1 was transferred to a higher level of care. R1 returned to the facility with orders for continuous oxygen even during baths. The facility failed to ensure R1 received his physician-ordered oxygen as required resulting in respiratory distress and arrest. This failure placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of acute respiratory failure with hypoxia (inadequate supply of oxygen), COPD, congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and hypertension (high blood pressure). The Admission Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R1 was dependent on staff for toileting, hygiene, and donning footwear. R1 required maximum assistance from staff for bathing, lower body dressing, transferring to the bath, and ambulating ten feet. The MDS documented R1 required moderate staff assistance for upper body dressing, lying to sitting, sit to stand, chair to bed transfers, and toilet transfers. The MDS documented R1 required continuous oxygen and a non-invasive mechanical ventilator (Bi-Pap - a type of positive pressure ventilator to assist with breathing). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 05/12/24, documented R1 used oxygen continuously and used a Bi-pap. R1 received breathing treatments to help manage his respiratory status. R1 would become short of air with activities, at rest, and when lying flat. R1 slept in his recliner. The CAA documented R1 had multiple diagnoses that could cause alterations in his cognition. The Activities of Daily Living/Functional Rehabilitation Potential CAA, dated 05/12/24, documented R1 had required increased staff assistance since his readmission with supervision to dependent staff assistance with most care. R1's Care Plan documented R1 had COPD with shortness of breath and a history of hypoxic and hypercapnic (a condition where the blood has abnormally high levels of carbon dioxide) respiratory failure. The care plan directed staff to ensure R1 had oxygen on at 4L via nasal cannula while awake/during the day, continuously. The care plan directed staff to change R1's oxygen to a Bi-pap with oxygen at 4L during the night. Staff were to notify the nurse if R1 was complaining of shortness of breath or having signs and symptoms of difficulty breathing. The care plan directed staff to elevate R1's head of bed to semi-Fowlers (semi-upright) to fowlers (upright) or out of bed upright in a chair during episodes of difficulty breathing. The Physician's Order, dated 02/06/24, documented R1 was to have oxygen administered at 4L continuously. The Progress Note, dated 05/21/24 at 11:03 AM, documented LN H was called to the whirlpool room by LN G and CNA M at approximately 10:45 AM. LN G entered the room and saw R1's eyes rolled into the back of his head; R1 had a grey skin color and no respirations. R1 had no response to verbal or painful stimulation. LN H asked for assistance from Administrative Nurse D and Administrative Nurse E. LN H noted R1 did not have any supplemental oxygen on. CNA N retrieved the vital signs cart. R1's vital signs were assessed and R1 had a pulse of 66 beats per minute, a blood pressure of 154/71 millimeters per mercury (mmHg), zero respirations, and oxygen saturation of 76% (normal range between 95% to 100%). R1 did respond briefly and stated, I hear you, before going unresponsive again. Once supplemental oxygen was placed on R1 via nasal cannula, LN H instructed staff to set up R1's CPAP (continuous positive airway pressure [CPAP] ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) and R1 was taken immediately back to his room and the CPAP was applied with 4L of oxygen bled through. R1 became more responsive but continued to have irregular respirations. Staff transferred R1 to his bed with the full body lift. R1's oxygen saturation continued to be in the mid-80th percentile. After R1 was transferred to bed, the head of the bed was elevated, the CPAP mask was adjusted to reduce leaking, R1's oxygen saturation rose to the low 90s but his skin had a grey pallor (pale skin color). LN H remained with R1 until Emergency Medical Service (EMS) arrived to transfer R1 to the hospital. The Emergency Department Discharge Instructions, dated 05/21/24 at 01:55 PM, directed R1 to wear oxygen at all times as ordered even in the shower. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The undated Facility Incident Report documented on 05/21/24 at 09:58 AM CNA N assisted CNA M in transferring R1 from his recliner to the wheelchair so CNA M could take him for his bath. CNA M assisted R1 to the bath without any incident and notified LN G she completed R1's bath. LN G performed a skin assessment and performed skin treatments at approximately 10:30 AM to 10:35 AM and left the bathhouse to allow CNA M to finish getting R1 dressed. After getting R1 dressed, CNA M transferred R1 to his wheelchair. As soon as R1 sat in his wheelchair, R1 lost consciousness. CMA R entered the whirlpool room at the same time and saw R1 had lost his color and struggled to breathe. LN G was alerted and went to the whirlpool room. When LN G entered the whirlpool room, she saw R1's head laid back and R1 was extremely pale. LN G then requested help from LN H and sent CNA N for the vital signs cart. LN H entered the whirlpool room and saw R1 leaning back in his wheelchair, eyes rolled into the back of his head, skin pale and grey, and without visible spontaneous respirations. LN G requested assistance from Administrative Nurse D and Administrative Nurse E. R1's vital signs were assessed and R1 had no respirations and an oxygen saturation of 76%. LN G noted R1 did not have oxygen on and obtained and administered oxygen at 4L per minute per nasal cannula per orders. R1 became responsive for a moment and verbalized he could hear staff and again lost consciousness. R1's respirations remained irregular and labored. R1 was assisted back to his room where his Bi-Pap was administered. Staff notified R1's primary care provider who ordered to send R1 to the emergency room if R1's responsible party was okay with it. Staff contacted R1's responsible party who requested R1 be sent to the emergency room . Staff assisted R1 to bed via the full body lift and R1 gradually returned to normal alertness. EMS arrived at 10:58 AM. R1 continued to be pale with labored respirations but was alert and oxygen saturations were back in the low 90th percentile. Staff assisted EMS in transferring R1 to a stretcher and turned over care. EMS exited the facility at 11:10 AM. R1 was seen at the local hospital, and they reported no respiratory distress upon R1's arrival. CNA M's undated Witness Statement documented that while CNA M bathed R1, CNA M forgot to put R1's oxygen on. CNA M stated R1 was doing okay when she asked him. CNA M stated R1 talked to her while she gave him a bath. CNA M stated after she got R1 dressed and back into his wheelchair, R1 lost consciousness. CNA M stated she got the charge nurse right away. CNA M stated R1 got his CPAP on and transferred to his bed and then was transferred to the emergency room by EMS. CMA R's undated Witness Statement documented R1 was in the bathhouse with CNA M. CMA R walked into the bathhouse to see how far along the bath was. CMA R stated when she opened the door, she saw R1 in his wheelchair and he had started to turn pale, almost white, and struggled to breathe. CMA R stated she called LN G and LN H over and then stepped out of the way while another aide obtained R1's vital signs. LN G's undated Witness Statement documented LN G was at the nurse's station when CMA R hollered and waved to LN G to come to the bathhouse. LN G stated when she got to the door, she saw R1 laid back in his wheelchair and was pale in color. LN G stated she hollered at LN H and ran to get the vitals sign cart and a stethoscope. LN G stated at that point LN H took over and LN G assisted with getting oxygen applied and getting R1 ready for transfer to the emergency room . (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LN H's undated Witness Statement documented LN H was called to the 300-hall whirlpool room at approximately 10:45 AM by LN G and CNA M. When LN H arrived at the whirlpool room, she saw R1 leaning back in his wheelchair; he had no signs of spontaneous respirations. LN H stated R1's eyes were rolled back, his skin was grey/pale in pallor, and he was unresponsive to verbal or painful stimuli. LN G stated she called for assistance from the administrative nurses. CNA M retrieved the vital signs cart and began to obtain vital signs. LN G stated she observed R1 did not have any supplemental oxygen, nor was there any oxygen in the whirlpool room. R1's oxygen saturation was 76%. CNA N arrived with an oxygen cylinder and supplemental oxygen was placed on R1 at 4L via nasal cannula. R1 briefly responded and stated, I hear you, before he became unresponsive again. LN G stated once oxygen was on R1, she took R1 to his room and immediately placed his CPAP on with supplemental oxygen bled in at 4L. R1 was then transferred to his bed utilizing the full body lift. R1 began to become more responsive though his oxygen saturation continued to read in the mid 80th percentile. R1 was placed in bed with the head of the bed elevated and the CPAP adjusted to reduce leaking air. R1's oxygen saturation began to rise to the low 90s. R1's skin continued to be pale and grey. LN H stated she stayed with R1 until EMS arrived and assisted in transferring the resident to the stretcher. Administrative Nurse E's undated Witness Statement documented she was in her office when a CNA knocked on her door and stated LN H needed help in the whirlpool room. Administrative Nurse E stated she saw R1 in his wheelchair with his head tilted back and flaccid (hanging loosely or limply) upper extremities. Administrative Nurse E stated LN H was already with R1 along with a couple of CNAs. R1 had agonal (intermittent gasps triggered as a brain stem reflex to lack of oxygen-rich blood, and a sign of impending death) breathing; a CNA brought in oxygen to place on R1. Since LN H was with R1, Administrative Nurse E went to get paperwork printed for transfer and then returned to the whirlpool room. LN H instructed staff to take R1 to his room to get his CPAP on and in bed to prepare for EMS transport. Once R1 was in his room, he knew where he was and was speaking. LN H applied R1's CPAP. CNA O's undated Witness Statement documented she witnessed CNA M holler for LN G. LN G went to the bathhouse and then got LN H. CNA O documented the nurses asked the CNAs to get R1's oxygen. CNA O stated she went to R1's room to look for the oxygen. CNA N came into the room and grabbed the tank and took it to the bathhouse. They wheeled R1 to his room and CNA O stated she assisted in getting R1 to bed and put his CPAP on R1. On 06/05/24 at 10:15 AM, observation revealed the whirlpool room/shower room was free of clutter and contained no supplemental oxygen in the room. During an interview on 06/05/24 at 10:20 AM, CNA N stated he helped CNA M get R1 up for the bath and into his wheelchair. CNA N stated R1 did not have any oxygen on when he left the room for the bath a little before 10:00 AM. CNA N stated CNA M asked him if R1 required oxygen and he told her that he did not know. CNA N went to R1's room to get R1's oxygen cylinder and saw the oxygen cylinder on the bed and not in R1's wheelchair holder. During an interview on 06/05/24 at 10:30 AM, LN G stated she went into the bathroom and saw R1 laid back in his wheelchair and his color was pale. LN G said she got another nurse to come help and LN H took over the situation. LN G stated R1 did not have oxygen on. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/05/24 at 10:35 AM, Administrative Nurse D stated she expected all of her CNAs to know the residents who required continuous oxygen and ensure that the oxygen was administered per the care plan. Administrative Nurse D stated CNA M said she simply forgot the oxygen and R1 was doing okay at first in the bath and then, after she got him out and dressed, he went unresponsive. During an interview on 06/05/24 at 01:10 PM Administrative Staff A stated the situation should not reflect badly on the facility. Administrative Staff A stated the situation was human error and the facility had done everything right: reported the incident, provided education, and had the appropriate protocols in place. Administrative Staff A stated the situation was not a sentinel event and should be scoped as such. The facility's Abuse, Neglect, Exploitation Policy, revised 10/01/22, documented neglect is the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility's Oxygen Therapy Policy, revised 08/20/18, documented it is the facility's policy that oxygen will be administered as ordered by the physician or in emergent situations until an order for flow rate can be obtained. On 06/05/24 at 01:15 PM Administrative Staff A was provided the Immediate Jeopardy [IJ] Template and notified the facility failure to provide R1 with continuous supplemental oxygen as ordered by the physician placed the resident in immediate jeopardy. The facility identified and implemented corrective actions, which were completed on 05/31/24, and included reeducation for all nursing staff on the importance of providing the necessary care including administering oxygen appropriately per orders. Appropriate staff completed an oxygen competency check-off completed. The incident was reviewed by the Quality Assurance Committee. Due to the corrective action completed before the onsite survey, the citation was deemed past noncompliance.